Chapter 1
Strengthening Systems for Workforce Planning and Development

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INTRODUCTION

The purpose of this *Update* is to further the goals, objectives and strategies put forward in the *Texas State Health Plan: Ensuring A Quality Health Care Workforce for Texas.* Many of the recommendations proposed in this *Update* by the Statewide Health Coordinating Council (SHCC) focus on strengthening four interdependent systems. Those systems are: workforce monitoring and forecasting; education and training; recruitment and retention; and regulatory systems that affect the health professions workforce. The SHCC in its vision statement has expressed its values for community development to improve health and the availability of health information to meet the needs of consumers. In this chapter, background on activities in each of these areas is presented and the SHCC recommendations pertaining to them are highlighted. A complete set of SHCC recommendations is presented in table format at the end of this chapter.

WORKFORCE MONITORING AND FORECASTING

Health care workforce monitoring and forecasting is directed toward informing policymakers of current or future imbalances between the supply and the needs for health professionals. Workforce planning allows for the identification of shortages, surpluses and maldistribution of health professionals by geographic region, specialty, and practice setting – conditions that can adversely affect access to care, quality of care, and health care costs.

The foundation for effective workforce monitoring and forecasting is the collection of accurate workforce data. The availability of timely, accurate, and accessible data on the state's health care providers is important for the following purposes:

- Tracking changes in the supply, distribution and composition of the state's health care workforce;
- Managing state dollars effectively to establish and support health professions education and training programs;

- Maximizing federal funds through programs such as the Health Professions Shortage Area designations and loan repayment programs for health professionals;
- Developing targeted recruitment efforts into the health professions based on identified need; and
- Supporting community-based public and private workforce planning and development efforts.

Appendix A of this *Update* reports on the work done by the SHCC's Ad hoc Committee on Health Personnel Data. That committee proposes a minimum set of data to be collected on selected licensed health professionals in Texas in order to shape workforce planning, higher education planning, decisions about distribution of state dollars for health professions education, and other policy decisions. The Ad hoc committee's study cited gaps in the data currently collected by the health professions licensing boards. The need for better workforce data was also highlighted in two other forums: the Texas Higher Education Coordinating Board's (THECB) long-range strategic planning effort and the Statewide Health Coordinating Council's Symposium on "Ensuring A Quality Health Care Workforce for Texas."

In September 1999 the THECB began a major long-range strategic planning effort to identify a small number of goals that the agency should pursue in the next five to ten years. As part of that study, the THECB established four task forces focusing on: Participation and Success, Civil Rights Issues, Technology Workforce, and Health Professions Education. The THECB contracted with the Council for Aid to Education, a subsidiary of the RAND Corporation, to help them accomplish this task. A primary finding of the Health Professions Task Force study is that better data on Texas's health professionals is necessary if Texas is to be assured that its higher education institutions can produce an adequate number of health care professionals. The THECB's board has adopted the following recommendation:

- Provide financial support to automate state data collection, including information about education of physicians, dentists, nurses, and allied health professionals.
- Direct health professional licensing and regulatory agencies to collect data using the *minimum data set* defined by the Statewide Health Coordinating Council's Ad hoc Committee on Health Personnel Data.

- This would allow state agencies and institutions of higher education to more easily share data and information about health professionals, while protecting the integrity and confidentiality of individual records and information.

The SHCC hosted a Symposium on health professions workforce issues on March 28, 2000. The need for better health professions data arose in panel discussions on workforce planning, nursing workforce, and allied health workforce issues. The SHCC and the Health Professions Resource Center have been most concerned with being able to track statewide health professions supply. However, presentations at the symposium made strong cases for the growing need for good data to support local workforce planning and development efforts. Texas' three Area Health Education Centers have a network of community-based centers that support local workforce development and stated they would benefit from enhanced data. Public/private partnerships formed by the Dallas-Fort Worth Hospital Council and the Dallas-Fort Worth Area Health Education Center to address nursing shortages, and the Greater Houston Partnership Health Services Steering Committee, which was formed to address skill shortages in the health professions in the Houston/Galveston area, serve as models that demonstrate the importance and the effectiveness of community-based health professions workforce planning efforts.

A Case For Workforce Data And Monitoring

The Nursing Shortage

Texas, with the rest of the nation, faces a nursing shortage crisis that could affect the quality and availability of health care to Texas' citizens. The importance of workforce data and ongoing workforce monitoring at the national and state levels is illustrated in this issue.

The early 90's were characterized by the projection of possible nursing surpluses, primarily due to the national and state responses to a nursing shortage in the late 80s.[1] However, by 1996, the Institute of Medicine convened a Committee on Nurse Staffing in Hospitals and Nursing Homes to evaluate the impact of changes in the health care delivery system on nurse utilization and the quality of care. In 1998, the United States Congress charged the Division of Nursing, U.S. Department of Health and Human Services, with implementing strategies to enhance the production of bachelor degree nurses (BSNs). In the same year, the Department of Veterans affairs

announced that by 2005 it would require that its nurses have a BSN degree due to the complex medical needs of veterans.[2]

What began as primarily a sharing of anecdotal stories attributing perceived declines in quality of care to a lack of registered nurses in the workforce led to the discussion of other nursing issues focusing on: the numbers of licensed but non-practicing nurses; the use of contract nurses; hospitals' inability to fill critical care nursing positions; decreasing enrollments in nursing degree programs; and the inability to hire doctoral trained nurses for faculty positions. Limited published research and lack of reliable and valid data made proving or disproving these anecdotal storied difficult. *Health and Nurses in Texas,* a study conducted by the Center for Health Economics and Policy at the University of Texas Health Science Center at San Antonio states:

> …warnings about surpluses a few years ago have been replaced with concerns about shortages in the nurse workforce. Unfortunately, lack of current data about nurses, their careers and work environment pose serious barriers to effective planning. Given the continuing expansion of the health care sector and the importance of nursing in delivering health services, timely and reliable information on this key human resource is needed with increasing urgency.[3]

Over the past two years there has been increased activity at both the national and state level to collect and maintain data systems for nursing workforce monitoring and planning. Based on empirical data collected on the nursing workforce in Texas and augmented by research at the national level, informed recommendations and policies for nursing education funding, faculty salaries, and strategies for recruitment into the nursing profession are being proposed. This case study illustrates the need for ongoing workforce monitoring for effective and timely health professions policymaking. Given the dynamics of the health care environment, workforce monitoring and planning does not ensure against possible workforce shortages. It does, however, ensure that information is available in order for policymakers and institutions of higher education to respond in as rapid and appropriate a manner as possible to a changing market.

State Initiatives

After a report by the SHCC's Ad hoc Committee on Health Personnel Data in January of 2000, the House Appropriations Regulatory subcommittee asked the SHCC to present testimony on health professions data. The subcommittee and the licensing boards expressed concern about the costs related to implementing the minimum data set proposed by the SHCC. Also, the 76th Legislature had requested that the Department of Information Resources perform a Regulatory System Requirements and Comparative Analysis. That study is to determine regulatory system requirements, improvements to regulatory data systems through technology, recommendations for system solutions, estimated costs to buy or build new systems, and strategies for funding the implementation of new systems. Seven of the fourteen regulatory agencies included in the study are health professions licensing boards. The House Appropriations Regulatory subcommittee asked the SHCC and the Health Professions Resource Center to conduct a pilot study in which certain health professionals, as a part of their license renewal, will be asked to go to a secure website and enter their workforce data. Numbers of health professionals responding and completeness of the data submitted will be analyzed and reported to the House Appropriations Regulatory subcommittee in January 2001.

While there seems to be a consensus among state agencies, institutions of higher education, and legislators on the importance of health professions workforce data, there is a concern about costs and a continued search for the best and most cost effective way to collect needed data. The SHCC hopes that the Ad hoc Committee report, the DIR Regulatory Systems and Comparative Analysis Study, and the pilot project conducted by the Health Professions Resource Center will provide the legislature with the information it needs to determine the most efficient and cost effective way to implement the minimum data set for health professionals.

SHCC Recommendations

The *Texas State Health Plan's* first goal is: "Ensure that the needed number of health care professionals are educated and trained." The accomplishment of that goal for Texas requires cooperation and collaboration among the many state agencies and universities, as well as other private and public partners. The SHCC, the THECB, and the Senate Committee on Health Services have all provided forums for the discussion of workforce issues and the formulation of solutions and recommendations. In this *Update*, the SHCC proposes the following strategies to strengthen the

workforce monitoring and forecasting systems (See Goal One, Strategy 1.1.1 and 1.1.2 for full text).

- The minimum data set, developed by the SHCC Ad hoc Committee on Health Personnel Data to improve information for workforce planning, allocation of educational resources, recruitment and retention of health professionals and evaluation of those programs; should be implemented and data collected on selected health professionals. The reporting of health personnel data is non-mandatory for health professionals, except for those data elements required for board administrative and regulatory purposes.
- The Health Professions Resource Center, the Texas Higher Education Coordinating Board, the Texas Workforce Commission, and the Research Division of the Texas Legislative Council should work cooperatively to conduct workforce projection studies and define and conduct workforce studies and surveys that will inform workforce and education policy development.

EDUCATION AND TRAINING

The *Texas State Health Plan* proposed goals, objectives and strategies for education and training of the health care workforce. The SHCC proposed a goal to "Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health." The strategy under that goal was to survey the Academic Health Centers on their programs, curricula, and other initiatives in implementing prevention activities. Appendix B of this *Update* includes the responses from the Academic Health Centers to the survey. In general, the reports from the medical schools, nursing schools, schools of allied health, public health, and dental health indicate changes in curricula, numbers and types of training sites, research, and other activities in this area.

The SHCC is convinced that improvement in health status will come about primarily through communities assessing and addressing their local health needs. The health care professionals in those communities have an important role to play in that community development. An Ad hoc committee was formed to address the core competencies of health professionals in working with communities. That Ad hoc committee was a strategy proposed to help attain the goal of "creating a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens." The

report of the Ad hoc committee on Community Competencies for Health Professionals is included as Appendix C in this *Update.* The SHCC proposes the following strategy to develop the skill level of health professionals in working with communities with its citizens (see Goal 6, Strategy 6.2.1 for full text.).

> The core competencies outlined in the Community Competencies for Health Professionals report should be integrated into professional associations' accreditation, certification, continuing professional education and licensure processes. Institutions training health professionals should incorporate them as benchmarks for graduation, entry into professional practice and continuing competence.

In considering demographic factors, which affect health care needs, the SHCC requested that the Texas Department on Aging study aging population health issues and their relationship to health workforce education, planning, and practice. The report referred to in the above strategy is included as Appendix C in this *Update.* Based upon this report, the SHCC recommends further study with a focus on forecasting health specialties that are needed to fulfill the health care needs of this population. Each of the reports produced from strategies proposed in the *Texas State Health Plan,* furthers the SHCC's goal to ensure a quality health care workforce for Texas.

In addition to these reports produced for this *Update,* the Texas Higher Education Coordinating Board embarked upon an ambitious strategic planning process that included a focus on health professions education and training issues. The SHCC's legislative mandate directs it to work collaboratively with the Texas Higher Education Board (THECB) to make recommendations on health professions workforce education and training. The THECB has appointed Dr. Dolores Carruth as its representative to the SHCC. During the THECB's strategic planning process, Dr. Ben G. Raimer, Chair of the SHCC, was a member of the THECB Health Professions Task Force.

The THECB's Health Professions Task Force was charged to:

- Review information on the quality, accessibility, productivity, and cost of the health-related programs offered by Texas higher education institutions;

- Review information on the demand for health profession in Texas and its major regions over the next 10 years; and
- Identify the best strategies by which higher education can produce an adequate number of appropriately trained health care professionals for Texas and its major regions.

The Health Professions Task Force established subcommittees in the fall of 1999 in the areas of medicine and dentistry, nursing, and allied health to study health professions education issues and make recommendations. Some of the issues discussed in these task forces are highlighted in the following sections.

THECB Subcommittee on Medicine and Dentistry

Of major concern to the medical and dental schools are the financial repercussions to medical schools and teaching hospitals due to decreases in federal financing under Medicare and Medicaid and decreases in revenues resulting from cost containment measures. The issue of establishing new medical schools in the state was considered but not supported due to the belief that new schools would weaken existing health-related institutions, jeopardize national accreditation, require extensive new state general revenue funding, and take several years to gain accreditation. The medicine and dentistry subcommittee proposed a set of recommendations based on four themes.

Participation – Providing the broadest array of students access to medical and dental education.

Success – Ensuring that students who enter Texas medical and dental schools graduate, complete their medical training, and enter the profession with the technical and critical thinking skills necessary to deliver quality care. Success also includes retaining graduates to practice in Texas.

Workforce – Preparing and training the required number of physicians and dentists to meet the needs of Texas growing population.

Technology - Ensuring that medical and dental students have access to, understanding of, and the appropriate training to utilize advances in technology that will translate into better health care delivery for Texas.

The subcommittee submitted their recommendations in these areas to the THECB long-range strategic planning committee. The SHCC supports several of the proposed

recommendations. Some of the medicine and dentistry subcommittee's recommendations are included under the SHCC's Goal One, Strategy 1.1.3b, while others are incorporated under goals and strategies related to recruitment and retention and the maldistribution of health professionals.

THECB Subcommittee on Nursing

Of prime importance to the nursing subcommittee was the issue of the nursing shortage and the actions that could be taken by the THECB, the Texas Legislature, and higher education institutions offering degrees in nursing. Past nursing shortages have been regarded as cyclical; however, recent studies indicate that the current nursing shortage is due to fundamental changes in society, the delivery of medical care, and an aging nursing faculty and workforce.[4] Solutions to this nursing shortage will require different responses than those taken in the past.

The nursing subcommittee proposed a number of recommendations to the THECB strategic planning committee. The SHCC supports the following recommendations for nursing (See Goal One, Strategy 1.1.3c for full text.):

- The THECB should support a moratorium on new nursing education programs until data indicate an adequate number of qualified nurse faculty and clinical sites are available.
- The legislature should increase funding for nursing schools for recruitment, retention and graduation of professional nurses, expanding distance-learning programs, and increasing faculty salaries.

THECB Subcommittee on Allied Health

The subcommittee on Allied Health began by producing a document entitled, *Allied Health Professions Education: A Primer,* in response to the need for the Health Professions Task Force to understand the diversity of occupations, roles, education, certifications, licensures, and accreditations that make up the field of allied health.[5] Allied health professionals comprise over 60 percent of the entire health care workforce. They may receive their education and training from high schools, vocational schools, community colleges, universities, and hospitals. This primer defines allied health professionals, identifies issues related to allied health education, and discusses the role the market plays in the demand for allied health workers. The Subcommittee on Allied Health also structured their recommendations along the

themes of participation, success, workforce and technology. The SHCC supports the following recommendations (See Goal One, Strategy 1.1.3d for full text.):

- Create incentives for institutions of higher education to form partnerships in the delivery of allied health programs to improve student participation across the state.
- Improve articulation of courses from the community colleges to the universities and health science centers.
- Review the impact of formula funding policies that hinder the development and implementation of programs.
- Simplify and shorten the THECB and institutions of higher education approval processes for instructional programs in order to provide a more timely response to the changing needs of the health care industry.

Some of the issues explored by the THECB Health Professions Task Force were also discussed in the larger forum of the SHCC Symposium. Also, during the fall and spring of 1999 – 2000, many of the issues were presented to the Senate Committee on Health Services, charged to study health professions workforce issues. These separate studies and forums for discussion have served to bring a focus to health professions education issues and build consensus among state agencies and higher education institutions around health professions workforce issues.

Other Related State Initiatives

The Texas Department of Health and the THECB are currently preparing a report on health professions education needs in the Texas-Mexico Border which was mandated through House Bill 1378, passed in the 76th Texas Legislature. That report will review health care needs, health care facilities, workforce resources, state government health care costs, number and location of state-operated health education facilities, health education costs, trends in health education, and existing and future health professions degree and certificate programs. That report is due to the legislature in January 2001. The lieutenant governor also gave an interim charge to the Senate Finance Committee to study Graduate Medical Education (GME) funding and to make recommendations for the 77th Legislative session. According to the *Annals of Internal Medicine*:

> The Balanced Budget Act of 1997 (BBA) had a profound impact on the financing and organization of many health care services. The Act disproportionately affected U.S. teaching hospitals, leading to

> substantial budget reductions in many institutions and the threat of cuts in major programs and services that teaching hospitals provide to communities.[6]

An Association of American Medical Colleges Fact Sheet published in May 2000 shows that the financial condition of America's teaching hospitals has declined due to reductions in both public and private revenue resulting from the BBA and the growth of managed care.[7] The resulting financial crisis in teaching hospitals dramatically affects GME, specifically funding related to the training of medical residents. The 76th Legislature implemented formula funding ratios for health professions education, but did not address the issue of GME. The Senate Finance Interim Committee on GME is working with the THECB to develop and propose a funding formula for GME to be presented to the 77th Legislature.

RECRUITMENT AND RETENTION

The importance of recruitment and retention activities to ensuring a quality health care workforce is the focus of both the SHCC Ad hoc Committee on Recruitment and Retention and the SHCC Ad hoc Committee on Minority Health Reports (See Appendices E and F). This was also a theme underlying all of the THECB Health Professions Task Force subcommittee reports and recommendations. Recruiting people into the health professions is an essential first step in building and maintaining a quality health care workforce. The second step is supporting those students who have chosen to enter a health profession. The third step is retaining those students to practice in Texas and recruiting them to practice in medically underserved areas. To be effective the state needs to strengthen those three steps through collection of data, coordination of efforts, increasing minority recruitment, and supporting community level recruitment and retention efforts.

The SHCC Symposium panel on Workforce Supply and Demand highlighted the importance of having good data to monitor workforce supply and demand. From that data, local, regional and statewide workforce needs can be assessed. That data can then be used to develop workforce plans and target recruitment efforts to specific health professions needs. The workforce development and planning projects by the Greater Houston Partnership and the Dallas Fort Worth Area Health Education Center presented at the SHCC Symposium demonstrate the power of local public and private efforts to address health professions workforce efforts. Those local planning efforts

explored local needs, derived local solutions and formed public/private partnerships to address those needs through targeted recruitment and student support.

There are a number of systems in place to support local, regional, and statewide recruitment and retention efforts.

Health Professions Resource Center – the role of this center is to maintain comprehensive health professions databases on licensed health professionals in Texas. The HPRC maintains a website displaying information on health professions shortage areas and workforce distribution by county.

Center for Rural Health Initiatives – is expanding the Texas PRAIRIE DOC program, which is a comprehensive recruitment approach, involving communities and other partners and participants.

Texas Higher Education Coordinating Board – administers physician loan repayment programs. The Family Practice Residency Program instituted in 1979 has resulted in the retention of 87 percent of resident physicians remaining and practicing in Texas with 48 percent of those locating practices in cities with 50,000 population or less.

Area Health Education Centers – have statewide community-based centers, which support workforce development and planning, recruitment programs, identification of clinical training sites, and continuing professional education and other professional support services.

Texas Department of Health Programs – the Texas Department of Health's Office of Border Health, Office of Minority Health, and the Primary Care Resources Program also have an emphasis on health professions recruitment and retention.

University Programs – Texas' 137 public community and technical colleges, and general academic and health-related institutions of higher education offer health professions degrees and support recruitment efforts. Key examples of these types of programs are Texas A&M University System's Partnership for Primary Care, and the Medical School Familiarization Program through the University of Texas Medical Branch at Galveston.

Professional Associations – such as the Texas Academy of Family Physicians, the Texas Medical Association, the Texas Osteopathic Medical Association, and the Texas Nurses Association support workforce planning and recruitment initiatives.

In order to better support all of these initiatives the SHCC proposes a number of strategies under Goal Three "Address the maldistribution of health professionals," with the Objective of "increasing access to health care through the coordination of recruitment and retention efforts." (See Goal 3, Objective 3.2 for full text.)

- Strategy 3.2.1. The state should enhance recruitment and retention of health professionals into Health Professional Shortage Areas by expanding state financial incentives, including, but not limited to, loan repayment, loan forgiveness, scholarship, grant programs and accessing federal matching dollars through the National Health Service Corps. Financial incentive programs should be established for all health care professionals.

- Strategy 3.2.2. The Statewide Health Coordinating Council should convene a collaborative partnership of state agencies, Academic Health Centers, Area Health Education Centers, professional associations and others to coordinate statewide recruitment and retention efforts of health professionals.

Recruiting and Retaining Minorities in the Health Professions

The SHCC Ad hoc Committee on Minority Health established a need for more minorities in the health professions through its discussion of under-representation of minorities in the health professions, disparities in health status and treatment of minorities, and the projected demographic changes in Texas's population. The THECB recommends: "Supporting and encouraging regional planning efforts among secondary schools, health professional programs, and health care employers to develop strategies for recruitment and retention of students reflective of the state's diverse population." This was a result of each Health Professions Task Force subcommittee's (Medicine and Dentistry, Nursing, and Allied Health) proposed recommendations to expand and enhance programs directed toward recruiting minorities into the workforce.

Recruitment of minorities into the health professions is an educational pipeline issue that must be addressed with academic preparation in the elementary and secondary schools. The Healthy People 2010 program developed by the Centers for Disease Control and Prevention has a goal to eliminate health disparities and provides some focus and direction to states' efforts to achieve the same goal. The SHCC proposes the following strategies (see Goal 5, Objective 5.1 for full text):

- Educational institutions at all levels, elementary, secondary, community college and university, should plan, implement, and strengthen their health professions programs to meet the Healthy People 2010 goals and strategies for increasing the number of minorities in the health professions.
- The Texas Department of Health's Office of Minority Health should review the Healthy People 2010 goals and strategies related to reducing disparities in health status in minority populations, and promote and coordinate efforts by programs in TDH, other Health and Human Services agencies, and private and public organizations to meet those objectives.
- The Texas Board of Health should establish an advisory committee to the Office of Minority Health.

REGULATION OF HEALTH PROFESSIONALS

The SHCC has identified two areas where regulation affects or may affect health professions and the assurance of access and quality care to all Texans. Those areas include the process in changing health professionals' scopes of practice, telemedicine and public health workforce initiatives.

Scope of Practice

Scopes of practice, as defined in the medical practice acts, delineate what duties a health professional can perform, what prescription authority each one has and under what kinds of supervision duties can be performed. Changes in scopes of practice generally require legislative changes to the medical practice acts. Proposed changes in scopes of practice are of critical importance to the health professionals involved and to the general public. Changes in scopes of practice can provide ways to decrease the costs of medical care and increase the delivery of services to at-risk or rural and underserved populations, providing greater access to care. However, they also generate concerns for consumer protection, professional autonomy and livelihoods, quality of care and cost containment. State legislators are faced with making decisions

of such importance within the compressed time of a legislative session and frequently under a great deal of pressure from those professionals affected. In order for the legislature to make informed decisions on these issues, criteria for changing a profession's scope of practice or for licensing a new profession must be established. That process must include a discussion of these issues in a broader public forum and involve consumers, health professionals, hospitals and other health care employers, public health policymakers and others. Any process established should ensure patient safety and quality of care, demonstrate adequate professional competency, estimate potential cost benefits of the change, and increase in ability to expand access to care for rural and underserved populations.

The following speakers on the SHCC Symposium Panel on Scope Of Practice focused on a number of possible processes to effectively manage scope of practice issues. Dr. Ben Raimer, Chair of the Statewide Health Coordinating Council, cited the 1998 Pew Commissions Report which advocates that scope of practice issues be data based, use alternative dispute resolution processes, and that legislatures establish "sunrise" and "sunset" processes to license new professions or to change existing professions' scopes of practice.[8] Washington, Colorado, and Maine all have sunrise review processes which establish criteria for decision making, include public meetings and hearings, and include reports to the legislature with findings, recommendations and rebuttals.

Representative Patricia Gray, Chair of the House Committee on Public Health, commented on how time consuming issues of scope of practice are during a busy legislative session. Her experiences have led her to believe that a better process is needed to ensure that issues are fully explored and developed through a more inclusive and objective process so that legislators can be better informed to make scope of practice legislative decisions.

Dr. Bruce Levy, former Executive Director of the Board of Medical Examiners, also presented on the scope of practice panel. Dr. Levy believes that the rule making process can be an effective and flexible way to manage some scope of practice issues.

The rulemaking process can be invoked if it involves defining terms or language already in a statute, which describes the scope of practice for a particular profession. The appropriate licensing board(s) would negotiate with their constituencies and draft rules based upon the existing legislation. Rules can be amended and do not require legislative action.

Suzanne Marshall, Deputy Director of the Center for Public Policy Dispute Resolution at the University of Texas School of Law, described the services provided by the Center and how they could be incorporated into a formalized process for determining changes in scopes of practice. The use of alternative dispute resolution processes is a major component in the Pew Commission's recommended strategies for determining changes in scopes of practice (See Exhibit 1-1). Texas meets most of the recommendations relating to alternative dispute resolution through the Texas Governmental Dispute Resolution Act of 1997, which established the use of alternative dispute resolution by state agencies as state policy and provided the statutory framework for the development and use of alternative dispute resolution procedures for state government.

The issue of scope of practice determinations is an issue for the legislature. The SHCC has discussed concerns related to the current system. It has explored possible methods and processes that could be instituted. Given the current health care market, issues related to scope of practice will continue to proliferate. In the interests of assuring sound public policy for regulating health professions and quality of care for all Texans, the SHCC proposes the following action to fulfill the strategy of "creating a fair and equitable process for addressing changes in scopes of practice for health professionals in Texas." (See Goal 2, Objective 2.1 for full text.)

> The lieutenant governor or the speaker of the house should request a legislative interim study to establish a process for determining changes in scopes of practice. The study should review and recommend a process that would include, but not be limited to, sunrise review, alternative dispute resolution, and rulemaking.

Telemedicine

The lack of available qualified health professionals continues to be a major barrier to accessing health care in rural Texas and in some urban areas. Telemedicine technologies hold promise for providing greater access to medical care, ensuring

quality of care, and containing costs through early diagnosis and intervention. The SHCC views telemedicine as a strategy to address the maldistribution of health professionals and increase access to health care through technology.

In the *Texas State Health Plan,* the SHCC proposed that the state address issues related to telemedicine by appointing a task force to develop a statewide telemedicine plan that would increase access to medical care, extend the workforce, and enhance workforce training. Issues to be addressed in that plan included: establishing guidelines for the Telecommunications Infrastructure Fund Board (TIFB) on funding telemedicine projects; identifying and recommending a statewide telecommunications infrastructure for telemedicine; defining the role of medical schools, hospitals, and public health clinics; making policy recommendations to ensure the quality of care; designating a group to coordinate statewide telemedicine initiatives; and, reviewing and making recommendations on interstate licensing issues related to the use of technology.

A Texas House Research Organization Report entitled, *Telemedicine in Texas: Public Policy Concerns,* covers issues identified by the SHCC and addresses policy issues that have come to the forefront since the *Texas State Health Plan*. That report states, "The rapid growth of telemedicine raises issues for Texas lawmakers regarding public health and safety, financing, consumer protection, and regulation of medical practice." [9] Policy issues that are coming to the forefront pertain to: reimbursement, equipment standards, medical regulation, and confidentiality and security.

One of the major issues that has hampered the use of telemedicine technologies is federal and state reimbursement for services performed via telemedicine. The Texas State Insurance Code for private health carriers is very liberal in its reimbursement of telemedicine procedures and in presenting practitioners. However, both Medicaid and Medicare have strict limitations on the types of services that can be reimbursed and who qualifies as an eligible presenter. A May 2000 report by the Office for the Advancement of Telehealth at the Health Resources and Services Administration (HRSA) identifies required fee sharing between referring physician and specialist, and the Health Care Financing Administration's interpretation of eligible presenters as limiting factors to the advancement of telemedicine.[10]

These issues are being addressed in Texas and at the federal level. House Bill 1398, passed during the 76th Legislative session, established a Health and Human Services Commission Medicaid Telemedicine Advisory Committee. That committee is charged to develop legislative recommendations to improve telemedicine services and identify areas for expansion of telemedicine in the Texas Medicaid Program. That committee has been meeting and will make recommendations to the legislature in October of 2000. Additionally, at the federal level, several laws have been proposed in Congress. Senate Bill 2505 seeks to provide increased access to health care for Medicare beneficiaries through telemedicine. That bill eliminates fee sharing, eliminates the requirement for a tele-presenter and allows reimbursement in non-Metropolitan Service Areas, and rural and urban Health Professional Shortage Areas. The expansion of eligible presenters or the elimination of the requirement for a tele-presenter reflects the proposed use of telemedicine in home health care and monitoring patients from their home.

The SHCC proposes in its strategies to address the maldistribution of health professionals and improve access to care that:

> The State Legislature should include telemedicine third-party reimbursements for Medicaid, Children's Health Insurance Program, Texas Healthy Kids Corporation and other state-sponsored programs in the state's mandated coverage. The following practitioners should be considered for third party reimbursement for telemedicine/ telehealth services: physicians, dentists, clinical psychologists, advance practice nurses, physician assistants, certified nurse midwives, clinical social workers, occupational therapists, physical therapists, speech therapists, marriage and family therapists, and other licensed health care providers. The state should consider issues related to scope of practice, fraud and abuse, and quality of care (see Goal 3, Objective 3.1 for full text).

The state provides funding to build the state's telemedicine capacity through grants offered through the Texas Telecommunications Infrastructure Fund Board (TIFB). The Office of the State Auditor's report on the TIFB, released in February 2000, specifically cited the need for TIFB to better assess telecommunications needs (including telemedicine), seek input from professional advisory groups, increase collaboration with other state agencies, and fund more advanced projects (statewide networks) as allowed in their enabling legislation.[11] The SHCC includes telemedicine recommendations that relate specifically to the TIFB and funding (see Goal 3, Objective 3.1 for full text). They are:

The 77th Texas Legislature should address high Inter-LATA rates that limit the development and sustainability of rural telemedicine links by establishing a program through the Public Utility Commission's Universal Access Fund that can be accessed to offset Inter LATA rates.

The 77th Texas Legislature should amend the TIFB's enabling legislation to provide for the following:

a) Definition of telemedicine/telehealth to include store and forward, teleradiology, mandatory disease reporting and health alerts, continuing education for health professionals, prisoners' health programs, behavioral health services, counseling and mental health services.
b) Flexibility in telecommunications protocol/technology so that the most cost-effective connection can be instituted, e.g., DSL instead of T-1.
c) Independent, private practitioners who deliver direct patient care; beneficiaries who live in rural or underserved areas, accept Medicaid or Medicare patients, and connect to an Academic Health Center or regional hospital; should be eligible for TIF funding.

The Telecommunications Infrastructure Fund Board should consider the following telemedicine/telehealth funding priorities:

a) Projects that address the maldistribution of health professionals through the development of telemedicine technology in rural and underserved areas.
b) The development of telehealth institutes and telehealth curriculum development in Academic Health Centers for all health professions students.
c) Funding for evaluation of telehealth demonstration grants by independent researchers.
d) The development of statewide networks to improve health care delivery and administration specifically by working collaboratively with the Department of Mental Health and Mental Retardation, the Department of Health, and the Health and Human Services Commission.